CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155072	B. WIN			11/01/2	011
	ROVIDER OR SUPPLIER		•	2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN46107		
(X4) ID PREFIX TAG F0000	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Complaint IN000 federal/state deficallegations are cir F514.  Survey dates: Och 1, 2011  Facility number: Provider number AIM number: 10 Survey team: Joy Census bed type: SNF: 13 SNF/NF: 102 Residential: 14 Total: 129  Census payor typ Medicare: 16 Medicaid: 71 Other: 42 Total: 129  Sample: 3	297472 substantiated, ciencies related to the ted at F425, F431, and ctober 31 and November  000029 : 155072 00275200  yce Hofmann, RN	FO	000	The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusion so forth in the statement of deficiencies, or of any violating regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Creatlegation and requests a Pocentification Review on or af November 28, 2011. THIS FACILITY RESPECTFULLY REQUESTS A DESK REVIEULEU OF AN ONSITE POST SURVEY REVISIT. THANK	not ne et on of dible ost ter	
			-				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

HZBX11

Facility ID:

000029

If continuation sheet

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155072			(X2) MU A. BUIL B. WING	DING	NSTRUCTION  00	(X3) DATE : COMPL 11/01/20	ETED
	PROVIDER OR SUPPLIER			2002 AL	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0425	16.2.						
SS=D	residents, or obtain described in §483. facility may permit administer drugs if	and biologicals to its In them under an agreement 75(h) of this part. The unlicensed personnel to State law permits, but only supervision of a licensed					
	A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.						
	of a licensed phare consultation on all pharmacy services	mploy or obtain the services macist who provides aspects of the provision of s in the facility. ew and record review, the	F0	425	It is the practice of this facility		11/28/2011
	of receipt and dismedications that medications and reconciliation of including the free whom and pertinfailed to assure a medication for a resulting in the repain for 1 of 3 re	controlled medications quency, method, by ent documentation and vailability of pain			provide pharmaceutical servi (including procedures that as the accurate acquiring, received dispensing, and administering all drugs and biologicals) to resident. Pharmaceutical Services-accurate procedures. What corrective action will be accomplished for those residents found to have been affected by the deficient practices: Resident # B no location residents having the potential be affected by the same deficient practices.	sure ving, g of neet  or e t onger ner	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 BUILDING 155072 11/01/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2002 ALBANY ST **BEECH GROVE MEADOWS** BEECH GROVE, IN46107 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE practice will be identified and #B] what corrective action will be taken:The medication Findings include: administration record and narcotic control sheet will be audited for all residents receiving Resident #B closed clinical record was scheduled narcotic pain reviewed on 10/31/11 at 3:15 p.m. and medication by nurse indicated the resident was admitted to the management What measures will facility on 08/12/11 and re-admitted on be put into place or what systemic 08/30/11. Resident #B's diagnoses changes will be made to ensure that the deficient practice does included, but were not limited to, right not recur:Inservice/education lower extremity fasciotomyic cadaveric provided for licensed nursing staff skin graft, lung cancer, peripheral by DNS/ADNS and Pharmakon vascular disease, coronary artery disease, by 11/23/11: Policy and Procedure for ordering hypertension, hyperlipidemia, chronic medications, use of the EDK for pain, and gastroesophageal reflux initial doses, medication disorder. administration and documentation, narcotic sign out procedure, filing completed Review of hospital records dated 08/09/11 narcotic control sheets in the indicated Resident #B had a complicated resident record. The on-coming medical history. Resident #B had a left and off-going nurse will review iliac artery stent in December 2007 and the narcotic control sheet for each resident receiving underwent a right femoral popiteal bypass scheduled narcotic pain graft in 2008 for claudication in his right medication to ensure medications lower extremity. In 2010, Resident #B were given as ordered. The was diagnosed with stage IV lung cancer narcotic count binder was divided into 2 sections. One section and underwent chemotherapy. One month labeled scheduled narcotics and ago, Resident #B presented with an acute one section labeled PRN occlusion of the right fem-pop bypass narcotics. The resident narcotic graft and required emergency surgery with control sheets will be placed under the appropriate section to thrombectomy and endartectomy. assist in identifying those Resident #B was then over at a residents receiving scheduled rehabilitation facility to rehabilitate from narcotic pain this when he developed symptoms medications. DNS/Designee will monitor to ensure the narcotic consistent with compartment syndrome

NAME OF PROVIDER OR SUPPLIER  BEECH GROVE MEADOWS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  and was taken back to the operating room where the resident underwent fasciotomy with cadaveric skin grafting of the right lower extremity. There did appear to be some necrotic muscle in the area, and he developed a gangrenous toe and heel over the last couple weeks.  Review of a Discharge Summary from the hospital dated 08/12/11 indicated the resident's current medication list included, but was not limited to, oxycodone [narcotic pain medication] 20 mg [milligrams] - take one [1] tab by mouth 3 times daily for 14 days with the next scheduled dose to be given on 8/12/11 at 10 p.m.; hydrocodone-acetaminophen  SIRRET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN46107  STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN46107  STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN46107  CX5)  (X5) PREFIX (EACH DEFICIENCY) PREFIX TAG  COMPLETION DATE  Control sheets are reviewed at the beginning and end of each shift by the oncomoning/off going nurse. Medications not available will be ordered by the DNS/Designee upon notification by charge nurse. How the corrective action will be monitored to ensure the deficient practice will not recur: The DNS or designee will audit the narcotic pain control sheets to ensure all scheduled and prn narcotic pain medications were given and signed out on each individual sheet correctly. Scheduled and PRN pain medication orders will be reviewed and the medication cart will be audited to verify the medication is available and reconciled. Audit 3X/week times		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE COMPL	
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I III n m i nydrocodone-acetaminonnen i i leconcilea. Audit sa/week iilles i			_					
4		-	-					
(Notco) 10-323 trig per tables - take 1-2 month, then 1X/week times 1		,	• 1					
tabs by mouth every 4 hours as needed for month, 2X/month times 3 months.		=				•	nths.	
pain.; and acetaminophen 650 mg CR -  Results of audits will be		-	-				ı	
take 1 tab by mouth every 4 hours as  discussed at the monthly CQI meeting and action plans		-	_				,I	
needed for pain and fever.  meeting and action plans developed if needed. By what		needed for pain a	mu ievei.			•	ıt	
date the systemic changes will be		Danian - Cal B	harriaian Talankana			date the systemic changes w	ill be	
Review of the Physician Telephone completed: November 28, 2011			•			completed: November 28, 2	2011	
Orders dated 08/12/11 indicated, "Norco			,					
5/325 mg ii [2] po [by mouth] q [every] 4								
hrs [hours] prn [as needed]. May use until								
Norco 10/325 mg arrives then DC			g arrives then DC					
[discontinue]."		[uiscontinue]."						
The Medication Administration Record		The Medication	Administration Record					
[MAR] for the oxycontin 20 mg CR 1 tab		[MAR] for the o	exycontin 20 mg CR 1 tab					
by mouth 3 times for 14 days indicated it			-					
was started on 08/12/11 at 10 p.m. and								

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155072			LDING	NSTRUCTION  00	(X3) DATE : COMPL 11/01/2	ETED	
	PROVIDER OR SUPPLIER		р. үн	STREET A	ADDRESS, CITY, STATE, ZIP CODE  BANY ST		
	GROVE MEADOWS				GROVE, IN46107		
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	scheduled were of p.m. for the 3 do no narcotic sheet 08/16/11 [ for th MAR indicated to oxycodone 20 mtimes a day time 08/30/11-08/31/sent out to the horeturned on 08/3  The September 2 oxycontin was g 09/01/11 - 09/13 09/31/11 [with 2 on the 31st where September].  The narcotic sheet was given on 08/08/18/11 at 6 a.m. 09/03/11 [where 09/03/11 - 09/08 dose was given, starts with date of 09/10/11 and 09/11/11 and 09/11/11 op/11/11 op/11/11 each day, then of 19/17/11 op/18/11 each day, then of 19/12/11 each day, then of 19/12/11 op/18/11 each day, then of 19/12/11 each day.	11. The resident was ospital on 08/20/11 and					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/C	LIA (X2	) MULTIPLE CO	NSTRUCTION		(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		BUILDING	00		COMPL	ETED
		155072		VING	-		11/01/2	011
			р. ,		ADDRESS, CITY, STA	ATE ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			BANY ST	, 0001		
BEECH (	GROVE MEADOWS	S			GROVE, IN461	07		
					ONOVE, 114-01			
(X4) ID		STATEMENT OF DEFICIENCIE	1	ID		PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY		PREFIX	CROSS-REFERENCI	VE ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG		R LSC IDENTIFYING INFORM.		TAG	DEF	FICIENCY)		DATE
	missed or not sig	gned out on the narcot	ic					
	sheets.							
	The closed clinic	cal record indicated or	n the					
	August 2011 MAR Norco 10/325 mg 1 by mouth every 4 hours as needed [prn]							
	1							
		given on 08/13/11 3						
		11 2 times, and on						
		s. The Norco 10/325 r	ng					
	2 by mouth ever	ry 4 hours prn was						
	initialed as giver	n on the August MAR	as					
	given on 08/13/1	11 1 time, 08/14/11 2						
	~	2 times, 08/16/11 and						
		1 time, and on 08/18/1	1					
	_		1					
	~	The narcotic sign off						
		was missing for Augu	ust					
	2011.							
	Review of Phys	sician's Telephone Ord	ers					
	dated 08/16/11 a	a new order was writte	n					
		mg 1 by mouth at 10						
		nely and continue prn						
	_		Las					
	needed] orders a	is written.						
		ated this order was not	-					
	given as the MA	AR was initialed and						
	circled for dates	of 08/16/11 - 08/18/1	1					
	and indicated it	was unavailable.						
	The closed clinic	cal record lacked any						
		•	,,,,					
	_	t sheets for Norco 10/3	023					
	mg for August 2	2011.						
	There was a nare	cotic sign out sheet for	the					
FORM CMS-2	2567(02-99) Previous Versi	ions Obsolete Ev	ent ID: HZBX	11 Facility I	D: 000029	If continuation sh	neet Par	ge 6 of 20

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
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NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REECH (	GROVE MEADOWS				LBANY ST GROVE, IN46107		
					GROVE, 114-0107		710
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	L LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Norco 5/325 mg	twice at day at 10 a.m.					
	and 5 p.m. which started on 09/03/11						
	which was given at 8 a.m., 12 p.m., 3						
	p.m., on 09/05/11 it was given at 10 a.m.,						
	on 09/15/11 given at 1 p.m., and on						
	09/16/11, given	at 3 a.m					
		Nursing went through the					
		ecord of Resident #B and					
		nd the missing narcotic					
	_	or oxycontin and norco					
	_	and indicated during					
		01/11 at 3 p.m. the sheets					
		ated and the sign out					
		available was difficult to					
	follow.						
	Review of the fa	cility's policy on					
		Procedures dated 05/2009					
		rolled medications will be					
	· · · · · · · · · · · · · · · · · · ·	ifically ordered by the					
	-	Il controlled medication					
	_	d by the pharmacy in a					
	punch card. A c	• •					
	•	controlled medications.					
		trolled medication is					
	dispensed by the	nurse, the nurse will sign					
	the medication of	out on the control log.					
		e laws require that each					
		cation is accounted for.					
	_	is a part of the resident's					
	-	cal record. All controlled					
		to be kept under double					
	lock at all times.	"					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPL	
		155072	A. BUIL B. WINC			11/01/20	011
NAME OF P	ROVIDER OR SUPPLIER		1		DDRESS, CITY, STATE, ZIP CODE		
BEECH C	GROVE MEADOWS	<b>S</b>			BANY ST GROVE, IN46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	This deficiency r IN00097472.	elates to Complaint					
	3.1-25(e)(2) 3.1-25(e)(3)						
F0431 SS=D							
	be labeled in acco accepted profession the appropriate ac	cals used in the facility must rdance with currently conal principles, and include cessory and cautionary ne expiration date when					
	the facility must sto in locked compartr temperature control	n State and Federal laws, ore all drugs and biologicals ments under proper ols, and permit only nel to have access to the					
	permanently affixe of controlled drugs Comprehensive Drugs Control Act of 1970 abuse, except whe unit package drug which the quantity missing dose can	rovide separately locked, and compartments for storage is listed in Schedule II of the rug Abuse Prevention and 6 and other drugs subject to en the facility uses single distribution systems in stored is minimal and a be readily detected.	F04	431	It is the policy of this facility to	0	11/28/2011

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155072	B. WIN	IG		11/01/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					BANY ST		
BEECH (	GROVE MEADOWS	3		BEECH	GROVE, IN46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	label drugs and biological in		DATE
	1	maintain records and			accordance with currently		
		pt, usage, disposition,			accepted professional princip	oles,	
	and reconciliation of controlled medications for 1 of 3 residents reviewed				and include the appropriate		
					accessory and cautionary		
	for medications	in a sample of 3.			instructions, and the expiration date when applicable.Drug	on	
	[Resident #B]				records, label, store drugs ar	nd	
					biological:Drug records, labe		
	Findings include	:			store drugs and biological:W	hat	
					corrective action will be	lonto	
		sed clinical record was			accomplished for those resid found to have been affected		
		31/11 at 3:15 p.m. and			the deficient practices: Resi	•	
	indicated the res	ident was admitted to the			# B no longer resides in this		
	facility on 08/12	/11 and re-admitted on			facility How other residents		
	08/30/11. Resid	ent #B's diagnoses			having the potential to be afformation by the same deficient practic		
	included, but we	re not limited to, right			be identified and what correct		
	lower extremity	fasciotomyic cadaveric			action will be taken: The		
	skin graft, lung o	cancer, peripheral			medication administration red		
	vascular disease,	, coronary artery disease,			and narcotic control sheet wi		
	hypertension, hy	perlipidemia, chronic			audited for all residents recein scheduled narcotic pain	iving	
	pain, and gastroe	esophageal reflux			medication by nurse		
	disorder.				management.What measure		
					be put into place or what sys		
	Review of hospi	tal records dated 08/09/11			changes will be made to ens that the deficient practice do		
	indicated Reside	nt #B had a complicated			not recur:Inservice/education		
	medical history.	Resident #B had a left			provided for licensed nursing	staff	
		in December 2007 and			by DNS/ADNS and Pharmak	on	
	underwent a righ	nt femoral popiteal bypass			by 11/23/11: Policy and Procedure for ordering		
	graft in 2008 for	claudication in his right			medications, use of the EDK	for	
	lower extremity.	In 2010, Resident #B			initial doses, medication	-	
	was diagnosed w	vith stage IV lung cancer			administration and		
	_	hemotherapy. One month			documentation, narcotic sign	out	
	ago, Resident #E	B presented with an acute			procedure, filing completed narcotic control sheets in the	<b>!</b>	
	,	right fem-pop bypass			resident record. The on-com		
		d emergency surgery with			and off-going nurse will revie		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION		A. BUI	LDING	00		
		155072	B. WIN	IG		11/01/2	011
NAME OF I	PROVIDER OR SUPPLIER	<b>t</b>			DDRESS, CITY, STATE, ZIP CODE		
DEECH (	GROVE MEADOWS				BANY ST GROVE, IN46107		
				<u> </u>	GROVE, IN40107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
		nd endartectomy.			the narcotic control sheet for		5.112
	Resident #B was	·			each resident receiving		
		cility to rehabilitate from			scheduled narcotic pain		
		reloped symptoms			medication to ensure medica	itions	
					were given as ordered. The narcotic count binder was div	idad	
		compartment syndrome			into 2 sections. One section	riaca	
		ack to the operating room			labeled scheduled narcotics	and	
		nt underwent fasciotomy			one section labeled PRN		
		kin grafting of the right			narcotics. The resident narc	otic	
	_	There did appear to be			control sheets will be placed under the appropriate section	n to	
		uscle in the area, and he			assist in identifying those	110	
		grenous toe and heel over			residents receiving schedule	d	
	the last couple w	reeks.			narcotic pain		
					medications. DNS/Designee		
	Review of a Disc	charge Summary from the			monitor to ensure the narcotic control sheets are reviewed		
	hospital dated 08	3/12/11 indicated the			beginning and end of each s		
	resident's current	t medication list included,			by the oncoming/off going		
	but was not limit	ted to, oxycodone			nurse.Medications not availa	ble	
	[narcotic pain me	edication] 20 mg			will be ordered by the		
	[milligrams] - tal	ke one [1] tab by mouth 3			DNS/Designee upon notificate by charge nurse. How the	tion	
	times daily for 1	4 days with the next			corrective action will be mon	itored	
		o be given on 8/12/11 at			to ensure the deficient practi		
		odone-acetaminophen			will not recur:The DNS or		
		mg per tables - take 1-2			designee will audit the narco		
	` ′	very 4 hours as needed for			pain control sheets to ensure scheduled and prn narcotic p		
	1	ninophen 650 mg CR -			medications were given and	Jaiii	
	_	uth every 4 hours as			signed out on each individua	I	
	needed for pain a	-			sheet correctly. Scheduled a		
	needed for pain a	AIIG 10 V OI.			PRN pain medication orders		
	Review of the D	hysician Telephone			be reviewed and the medical cart will be audited to verify t		
		12/11 indicated, "Norco			medication is available and	110	
					reconciled. Audit 3X/week ti	mes	
		oo [by mouth] q [every] 4			1 month, then 2X/week times		
		as needed]. May use until			month, then 1X/week times 1		
		g arrives then DC			month, 2X/month times 3 mc Results of audits will be	onths.	
	[discontinue]."				IVESUITS OF AUDITS WILL DE		

	AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155072			ULTIPLE CO LDING IG	NSTRUCTION 00		X3) DATE SUR COMPLETE 11/01/2011	D
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, BANY ST GROVE, IN46107	ZIP CODE		
			1					(37.5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	E	(X5) OMPLETION DATE
	The Medication [MAR] for the oby mouth 3 times was started on 08 then stopped on scheduled were 6 p.m. for the 3 do no narcotic sheet 08/16/11 [ for the MAR indicated to oxycodone 20 m times a day times a day times out to the hor returned on 08/3 The September 2 oxycontin was given as the control of the c	Administration Record oxycontin 20 mg CR 1 tab as for 14 days indicated it 8/12/11 at 10 p.m. and 08/19/11. The times 6 a.m., 2 p.m., and 10 asses per day. There was at sign sheet for 08/12/11 - the first doses given]. The the resident received his as 14 days on 11. The resident was assistant on 08/20/11 and 0/11.			discussed at the meeting and acti developed if nee date the systemic completed: Nove	on plans ded. By what c changes wi	t II be	
		1/11 and from 09/24/11 - doses initialed as given						
	on the 31st when September].	n there is only 30 days in						
	was given on 08/ 08/18/11 at 6 a.n 09/03/11 [where 09/03/11 - 09/08 dose was given, starts with date of 09/10/11 and 09/12/ given, then 09/12/	the indicated oxycontin /16/11 at 10 p.m m., then from 08/30/11 - m. only 2 doses given, then 18/11 where only the 6 a.m. then a new narcotic sheet of 09/09/11 at 2 p.m., /11/11 with only 2 doses 2/11 - 09/13/11 with 3 m day, then skips to						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	HZBX11	Facility I	D: 000029	If continuation she	eet Page	11 of 20

		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL	
			155072	A. BUI B. WIN			11/01/2	011
N	AME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LBANY ST		
В	EECH O	GROVE MEADOWS	3			GROVE, IN46107		
P	(4) ID REFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
		09/16/11 with on 09/17/11 - 09/18, each day, then or given, then 09/20 doses given each missed or not sig sheets.  The closed clinic August 2011 MA mouth every 4 homouth every 98/15/11 2 times 2 by mouth every initialed as given given on 08/13/1 times, 08/15/11 2 08/17/11 given 1 given 3 times. To sheets for Norco 2011.  Review of Physical dated 08/16/11 a for Norco 5/325 and 5 p.m. routing needed] orders as the MAR indical given as the MAR indical	ally 2 doses given, then /11 with all 3 doses given in 09/19/11, only 2 doses 0/11 - 09/23/11 all 3 day. Several doses were med out on the narcotic ral record indicated on the AR Norco 10/325 mg 1 by ours as needed [prn] given on 08/13/11 3 days and on the Norco 10/325 mg y 4 hours prn was a on the August MAR as 1 1 time, 08/14/11 2 days missing for August was missing for August fician's Telephone Orders new order was written mg 1 by mouth at 10 a.m. ally and continue prn [as as written.  Ited this order was not R was initialed and of 08/16/11 - 08/18/11					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPL	
		155072	A. BUII B. WIN			11/01/2	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					BANY ST		
	GROVE MEADOWS			<u> </u>	GROVE, IN46107	-	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	The closed clinic	al record lacked any					
	narcotic sign out	sheets for Norco 10/325					
	mg for August 2011.						
		otic sign out sheet for the					
	_	twice at day at 10 a.m. started on 09/03/11					
	•	at 8 a.m., 12 p.m., 3					
	_	1 it was given at 10 a.m.,					
	* .	n at 1 p.m., and on					
	09/16/11, given at 3 a.m						
		Nursing went through the					
		cord of Resident #B and					
		of the missing narcotic or oxycontin and norco					
		and indicated during					
	_	01/11 at 3 p.m. the sheets					
		ated and the sign out					
	sheets that were	available was difficult to					
	follow.						
	Review of the fa						
		Procedures dated 05/2009					
	· ·	rolled medications will be fically ordered by the					
	•	l controlled medication					
	_	by the pharmacy in a					
	punch card. A co						
	-	ontrolled medications.					
	Each time a cont	rolled medication is					
	dispensed by the	nurse, the nurse will sign					
		ut on the control log.					
	Federal and state	laws require that each					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155072		(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY  COMPLETED  11/01/2011			
		155072	B. WING		11/01/2011		
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE  2002 ALBANY ST  BEECH GROVE, IN46107				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F0514 SS=D	The control log is permanent clinical medications are to lock at all times. This deficiency in 100097472.  3.1-25(n)  The facility must meach resident in accomplete; accurate accessible; and sy the clinical record information to identify the resident's asset and services provipreadmission screes tate; and progress Based on interviet the facility failed completed, organd documented clinical record information for interviet facility failed completed, organd documented clinical recessible for 1 completed for medication recessible f	relates to Complaint  naintain clinical records on coordance with accepted ards and practices that are ely documented; readily stematically organized.  must contain sufficient attify the resident; a record of essments; the plan of care ded; the results of any ening conducted by the se notes.  ew, and record review, to have maintained aized, and accurately deal records and failed to we sheets readily of 3 residents reviewed ecords in a sample of 3.	F0514	It is the policy of this facility to maintain clinical records on experience of the accepted professional standard practices that are completed accurately documented; read accessible; and systematical organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the of care and services provided results of any preadmission screening conducted by the State; and progress	each ards ete; dily ly d		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL		
		155072		LDING		11/01/20	
		1000.12	B. WIN		PROPERTY OF A TELEFORM	1170172	
NAME OF	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE LBANY ST		
BEECH	GROVE MEADOWS	8			GROVE, IN46107		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated the res	ident was admitted to the			notes.Resident Records –		
	facility on 08/12	/11 and re-admitted on			Complete/accurate/accessib hat corrective action will be	ie. vv	
	08/30/11. Resid	ent #B's diagnoses			accomplished for those resid	lents	
	included, but we	re not limited to, right			found to have been affected		
		fasciotomyic cadaveric			the deficient practices:Resid	-	
	1	cancer, peripheral			B no longer resides in this		
		coronary artery disease,			facility. How other residents		
	1	perlipidemia, chronic			having the potential to be aff		
		• •			by the same deficient practic be identified and what correct		
	1 .	esophageal reflux			action will be taken:The	,uv <del>C</del>	
	disorder.				medication administration re	cord	
					and narcotic control sheet wi		
	Review of hospi	tal records dated 08/09/11			audited for all residents rece	iving	
	indicated Reside	nt #B had a complicated			scheduled narcotic pain		
	medical history.	Resident #B had a left			medication. What measures		
	iliac artery stent	in December 2007 and			be put into place or what sys changes will be made to ens		
	_	at femoral popiteal bypass			that the deficient practice do		
	1	claudication in his right			not recur:Inservice/education		
	1	In 2010, Resident #B			provided for licensed nursing		
	1	vith stage IV lung cancer			by DNS/ADNS and Pharmak	on	
	1				by 11/23/11: Policy and		
		hemotherapy. One month			Procedure for ordering	£	
	1 -	B presented with an acute			medications, use of the EDK initial doses, medication	IOF	
		right fem-pop bypass			administration and		
	1 -	d emergency surgery with			documentation, narcotic sign	out	
	thrombectomy as	nd endartectomy.			procedure, filing completed		
	Resident #B was	then over at a			narcotic control sheets in the		
	rehabilitation fac	cility to rehabilitate from			resident record. The on-com	~	
	this when he dev	reloped symptoms			and off-going nurse will revie		
		compartment syndrome			the narcotic control sheet for each resident receiving		
		ack to the operating room			scheduled narcotic pain		
		nt underwent fasciotomy			medication to ensure medica	ations	
		kin grafting of the right			were given as ordered. The		
					narcotic count binder was div		
	I	There did appear to be			into 2 sections. One section		
		uscle in the area, and he			labeled scheduled narcotics	and	
	developed a gang	grenous toe and heel over			one section labeled PRN		

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	TE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	NUMBER:		BUILDING 00		COMPLETED	
		155072	B. WIN		11/01/2011			
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					BANY ST			
BEECH (	GROVE MEADOWS	3			GROVE, IN46107			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	the last couple w	reeks.			narcotics. The resident narc			
					control sheets will be placed			
	Review of a Disc	charge Summary from the			under the appropriate sectio	n to		
		3/12/11 indicated the			assist in identifying those residents receiving schedule	d		
	_	t medication list included,			narcotic pain	u		
					medications. DNS/Designee	will		
		ted to, oxycodone			monitor to ensure the narcot			
		edication] 20 mg			control sheets are reviewed			
		ke one [1] tab by mouth 3			beginning and end of each s	hift		
	1	4 days with the next			by the oncoming/off going	abla		
	scheduled dose to be given on 8/12/11 at 10 p.m.; hydrocodone-acetaminophen				nurse. Medications not avail will be ordered by the	able		
					DNS/Designee upon notifica	tion		
	(Norco) 10-325 i	mg per tables - take 1-2			by charge nurse.How the			
	tabs by mouth ev	very 4 hours as needed for			corrective action will be mon	itored		
	<u> </u>	ninophen 650 mg CR -			to ensure the deficient practi	ce		
	-	uth every 4 hours as			will not recur:The DNS or			
	needed for pain a	_			designee will audit the narco			
	l needed for pain a	and level.			pain control sheets to ensure scheduled and prn narcotic			
	D : C4 D	1			medications were given and	Jaiii		
		hysician Telephone			signed out on each individua	ıl		
		12/11 indicated, "Norco			sheet correctly. Scheduled a			
		oo [by mouth] q [every] 4			PRN pain medication orders			
		as needed]. May use until			be reviewed and the medica			
	Norco 10/325 m	g arrives then DC			cart will be audited to verify	ine		
	[discontinue]."				medication is available and reconciled. Audit 3X/week to	mes		
					1 month, then 2X/week time			
	The Medication	Administration Record			month, then 1X/week times			
		oxycontin 20 mg CR 1 tab			month, 2X/month times 3 mg			
		s for 14 days indicated it			Results of audits will be			
	1 *	8/12/11 at 10 p.m. and			discussed at the monthly CO	ΣI		
		-			meeting and action plans	t data		
		08/19/11. The times			developed if needed.By wha the systemic changes will be			
		6 a.m., 2 p.m., and 10			completed: November 28, 2			
	•	ses per day. There was						
		t sign sheet for 08/12/11 -						
	08/16/11 [ for the	e first doses given]. The						
	MAR indicated t	the resident received his						

000029

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155072	B. WIN	G		11/01/2	011
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
DEFOULODOUE MEADOWN					BANY ST		
	GROVE MEADOWS		ı		GROVE, IN46107		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFTY (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	,	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
		g CR 1 tab by mouth 3					
	times a day time						
	1	11. The resident was					
		ospital on 08/20/11 and					
	returned on 08/3	-					
	The September 2	2011 MAR indicated the					
	oxycontin was g	iven 3 times a day from					
	09/01/11 - 09/13	/11 and from 09/24/11 -					
	09/31/11 [with 2	doses initialed as given					
	on the 31st when there is only 30 days in September].						
		et indicated oxycontin					
		/16/11 at 10 p.m					
		m., then from 08/30/11 -					
	-	only 2 doses given, then					
		/11 where only the 6 a.m.					
	_	then a new narcotic sheet					
		of 09/09/11 at 2 p.m.,					
		/11/11 with only 2 doses 2/11 - 09/13/11 with 3					
	1	1 day, then skips to					
	_	•					
	09/16/11 with only 2 doses given, then 09/17/11 - 09/18/11 with all 3 doses given each day, then on 09/19/11, only 2 doses						
		0/11 - 09/23/11 all 3					
	1	day. Several doses were					
	missed or not signed out on the narcotic						
	sheets.	•					
	The closed clinic	cal record indicated on the					
	August 2011 MA	AR Norco 10/325 mg 1 by					
	mouth every 4 h	ours as needed [prn]					

·		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	LDING	NSTRUCTION  00	(X3) DATE COMPL 11/01/2	ETED
NAME OF I	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE		
				BANY ST		
	GROVE MEADOWS			GROVE, IN46107		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE	
		given on 08/13/11 3				
	· ·	11 2 times, and on				
	· ·	The Norco 10/325 mg				
		y 4 hours prn was				
	initialed as giver	on the August MAR as				
	given on 08/13/1	1 1 time, 08/14/11 2				
	times, 08/15/11 2	2 times, 08/16/11 and				
	08/17/11 given 1	time, and on 08/18/11				
	given 3 times. T	he narcotic sign off				
		was missing for August				
	2011.					
		=				
	1	ician's Telephone Orders				
		new order was written				
		mg 1 by mouth at 10 a.m.				
	_	nely and continue prn [as				
	needed] orders a	s written.				
	The MAR indica	ated this order was not				
		R was initialed and				
	~	of 08/16/11 - 08/18/11				
	and indicated it v					
	The closed clinical record lacked any narcotic sign out sheets for Norco 10/325 mg for August 2011.					
	There was a narc	cotic sign out sheet for the				
	_	twice at day at 10 a.m.				
	_	n started on 09/03/11				
	_	at 8 a.m., 12 p.m., 3				
	_	1 it was given at 10 a.m.,				
	_	en at 1 p.m., and on				
	09/16/11, given a	at 3 a.m				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL		
		155072	B. WIN			11/01/2	011
NAME OF	PROVIDER OR SUPPLIER	·	_		ADDRESS, CITY, STATE, ZIP CODE	•	
BEECH GROVE MEADOWS					_BANY ST GROVE, IN46107		
					GROVE, IN40107		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	The Director of closed clinical re was unable to fin sign out sheets for August 2011 interview on 11/could not be locally sheets that were follow.  Review of the far Administration I indicated, "Contifiled when specially mursing staff. A will be dispensed punch card. A caccompany the caccompany that can be calculated as a controlled medication are lock at all times.	Nursing went through the ecord of Resident #B and and the missing narcotic for oxycontin and norco and indicated during 01/11 at 3 p.m. the sheets ated and the sign out available was difficult to cility's policy on Procedures dated 05/2009 rolled medications will be ifficially ordered by the ll controlled medication dby the pharmacy in a control log will controlled medications. Trolled medication is a nurse, the nurse will sign out on the control log. It is a part of the resident's tall record. All controlled to be kept under double				ile	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY  COMPLETED  11/01/2011	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN46107	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE